State Optional Life and SLTD Premium Waiver Form

Employee name:	Employee SSN:
Group name:	Group number:

Optional Life
Policy No. GL33913

INITIATE OPTIONAL LIFE PREMIUM WAIVER

The employee listed is in a leave of absence due to a total disability and we are requesting that his Optional Life insurance be continued with his premiums waived for up to 12 months from the last day physically at work. His last day physically at work was (date) _____.

TERMINATE OPTIONAL LIFE PREMIUM WAIVER

The employee listed returned to work on (date) _____ and is no longer eligible for the Optional Life premium waiver effective (date) _____.

The employee listed is still in an approved leave of absence status; however, the 12-month waiver of premium has expired and his Optional Life should be terminated effective (date) _____. The employee is being advised of conversion/portability rights, whichever is applicable.

Supplemental Long Term Disability
Policy No. 621144

TERMINATE SLTD PREMIUM WAIVER

The employee listed returned to work on (date) _____ and is no longer eligible for the SLTD waiver effective (date) _____.

Benefits Administrator's Signature **Date**

Send completed form to the Office of Insurance Services.